LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

January 27, 2015

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/CONSULTANTS
Brad Land, *Co-Chair*	Al Ballesteros, MBA, *Co-Chair (on sabbatical)*	Whitney Engeran-Cordova	Jane Nachazel
Michelle Enfield		Deborah Collins	Yeghishe Nazinyan, MS, MD
Miguel Martinez, MPH, MSW	Abad Lopez	Michael Pitkin	
Juan Rivera	Marc McMillin	Scott Singer	
Ricky Rosales	Mario Pérez, MPH	Terry Smith	**DHSP STAFF**
Sabel Samone-Loreca	Monique Tula	Jason Wise	Angela Boger
LaShonda Spencer, MD			Carlos Vega-Matos, MPA
			Juhua Wu, MS

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1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *1/27/2015*
2) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *7/22/2014*
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *8/12/2014*
4) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *8/19/2014*
5) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *8/26/2014*
6) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *9/16/2014*
7) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *10/28/2014*
8) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *11/18/2014*
9) **PowerPoint**: Medical Care Coordination Implementation Update, *1/27/2015*
10) **PowerPoint**: Update on the Implementation of Ambulatory Outpatient, *1/27/2015*

1. **CALL TO ORDER:** Mr. Land called the meeting to order at 1:10 pm.

2. **APPROVAL OF AGENDA:**
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES:**
   MOTION #2: Approve minutes from the 7/22/2014, 8/12/2014, 8/19/2014, 8/26/2014, 9/16/2014, 10/16/2014, 10/28/2014 and 11/18/2014 Planning, Priorities and Allocations (PP&A) Committee meetings, as presented **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)*:** Mr. Pitkin suggested each PLWH not already undetectable should be asked individually what would help him/her achieve undetectable status. Often clients themselves know best what would help them. He also preferred the term "client" as more standard in general health services than "consumer."

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)*:** There were no comments.

6. **CO-CHAIRS' REPORT:**
   - Mr. Land noted, per the last meeting, he invited the City of Long Beach in writing. Ms. Collins was the City's representative.

- He emailed Ms. Tula the Executive and prior PP&A work plans as well as PP&A agendas through March 2015 for review. They will develop a new draft PP&A work plan for Committee review after her return to Los Angeles in early February.
- The Comprehensive HIV Planning Task Force met earlier that day. It suspended further meetings until the Executive Committee can review input from the Commission's Annual Meeting or as needed.

7. MEDICAL CARE COORDINATION (MCC) PRESENTATION:

- Ms. Boger, BA, Staff Analyst, Health and Mr. Vega-Matos, Chief, Care Services presented a PowerPoint, "Medical Care Coordination (MCC) Implementation Update." Ms. Boger participated in MCC development and is involved in its evaluation.
- MCC allocations began in November 2012. The first full MCC contract year was 3/1/2013 to 2/28/2014. YR 24 (3/1/2014-2/28/2015) is the second. Three years are needed for statistical reliability so data is preliminary. Screening and intervention data are from January 2013 to June 2014 with viral suppression data at six months from January 2013 to May 2014
- As of August 2014, 43 MCC teams were in place at 35 HIV/AIDS clinics: 17 Community Based Organizations (CBOs), 24; Department of Health Services (DHS), 9; City of Long Beach and City of Pasadena health departments, 1 clinic each.
- Nearly $10 million is invested in MCC with approximately $5 million invoiced. DHSP expected savings due to staff vacancies and contract augmentations late in the term, but contractors would likely exceed the goal of 4,960 unique patients.
- Mr. Vega-Matos noted numbers reflect patients with acute needs receiving active MCC. Ms. Boger added approximately 8,947 people were screened with 61% self managed, i.e., not needing or accepting active MCC at screening.
- Main goals are increased retention in care, improved health outcomes and reduced HIV transmission. Initial screening is 13 questions including psychosocial issues, e.g., substance abuse, mental health and incarceration. Full assessment is triggered by any one criterion or primary care physician request. Active MCC includes planning care and brief interventions. Those more likely to need active MCC are: Black, younger, homeless, post-incarcerated and at/below the Federal Poverty Level.
- Mr. Vega-Matos said DHSP designed a quick initial screening to facilitate incorporation in varied clinic patient flow structures, e.g., at intake or during a physician appointment. MCC was developed based on clinical criteria to identify those with unsuppressed Viral Load (VL), intermittent medical appointments or an indication of mental health or addiction issues.
- Casewatch data, January 2013 -May 2014, reflects PLWH with VL suppression (<200 copies/ml) increased from 27.6% to 61.9% at six months post-MCC. The 580 patient subset had Ryan White or Healthy Way LA (Medicaid expansion) insurance.
- Mr. Singer felt it would be helpful for allocations to review cost per service unit or per patient, cost-effectiveness and improvement of cost effectiveness over time. Ms. Boger replied YR 23 data indicates an approximate cost of $1,100 per patient which is less than Case Management, Psychosocial. Protocols, forms and acuity levels are on the DHSP website.
- ➲ Wendy Garland, DHSP, will report on updated MCC data when available to PP&A, Standards and Best Practices (SBP) and afterwards to the full Commission.

MOTION #3: Approve the Medical Care Coordination (MCC) presentation, as presented **(*Passed by Consensus*)**.

8. AMBULATORY OUTPATIENT MEDICAL (AOM) PRESENTATION:

- Mr. Vega-Matos presented a PowerPoint, "Update on the Implementation of Ambulatory Outpatient." DHSP currently funds 20 HIV providers (19 CBOs and DHS) to deliver AOM and MCC HIV care services at 40 clinic sites.
- Patient migration, Fee For Service (FFS) implementation and data reporting changes are all key changes to medical outpatient services since 2012. Significantly, Ryan White-eligible patients for AOM services have declined due to migration to LIHP/Medicaid Expansion and ACA services as well as better eligibility tracking and reporting.
- There were 16,995 reported patients and 82,871 reported visits in FY 2011. Starting in FY 2012, migration due LIHP, Medicaid Expansion and ACA as well as better eligibility tracking and reporting of other payer sources has led to continuing AOM service utilization declines: FY 2012, 16,599 patients, 70,693 visits; FY 2013, 9,903 patients, 33,611 visits; FY 2014, 7,043 patients, 17,981 visits; estimated FY 2015, 4,036 to 6,055 patients, 24,221 visits.
- DHSP requested the Board extend AOM contracts for two years based on YR 25 projections from YR 24 data. The FFS contracts include funding for, e.g., pharmacy and laboratory costs. Funds can be re-allocated within contract areas.
- DHSP had just completed contract monitoring using 30 measures including four measures pertaining to eligibility.
- Previously, DHSP received a monthly report from providers which included a narrative. The new report only includes data. DHSP receives other provider input through, e.g., conference calls and the Medical Advisory Committee. Most reported challenges pertain to changes in payer sources and migration, e.g., issues with interfaces and data transfers.
- Projections indicate a continued decline of Ryan White-eligible AOM patients due to migration to LIHP and ACA payer sources in addition to improved payer source tracking and reporting. The average number of annual visits for most Ryan White patients has also been declining despite subsets of some 500 patients who require 6+ and 100 patient who need 10+.

- Consequently, AOM needs to be resized to reflect reduced need while other services should be reviewed for potential increased funding. Ryan White can fund AOM while, e.g., a patient's Medi-Cal application is pending, but charges will be backed out after an application is accepted because it cannot fund non-Ryan White services.
- Ryan White can fund services if a patient is under-insured, e.g., Kaiser does not fund inpatient substance abuse services so a patient could qualify for Ryan White services. It is important for financial screeners to advise patients of all their options.
- Mr. Rivera stressed the importance of addressing the full continuum of services so that HIV- people have access to services they need such as substance abuse to support them in remaining HIV-.

➲ Mr. Vega-Matos will report on issues raised by providers at the Medical Advisory Committee at the next PP&A meeting.

➲ Mr. Vega-Matos will forward AOM data on various performance measures, e.g., retention in care and reduction of VL, to the PP&A, SBP and Executive Committees.

➲ DHSP will report on feasibility of prior PP&A recommendations to increase or initiate allocations for services besides AOM.

MOTION #4: Approve the Ambulatory Outpatient Medical (AOM) presentation, as presented **(*Passed by Consensus*)**.

9. **FOLLOW-UP OF SERVICE PLANNING AREA UTILIZATION EQUITY**:
   A. **Review City of Long Beach's Casewatch, Surveillance and FY 15 Utilization Data Projections**:
      - Mr. Rosales noted the 4th Supervisorial District Office requested Commission input on this matter. On review, the Commission requested PP&A inform its response. Mr. Land reported Mario Pérez committed DHSP at the 1/20/2015 meeting to provide data today for PP&A review, but Mr. Vega-Matos had not been informed and did not have the data.
      - Mr. Engeran-Cordova, AIDS Healthcare Foundation, noted AOM was last bid out in 2010. There has been a major shift in the health care delivery system since then yet he felt the County's structure was not sufficiently nimble to respond.
      - Other jurisdictions have developed alternative structures, e.g., a Florida jurisdiction uses an annual contract of approximately four pages and sweeps underutilized funds from one contract to another as utilization indicates.
      - Mr. Singer suggested shortened RFP cycles could improve contract responsiveness, but felt the Commission was not the appropriate discussion venue. Mr. Land replied the Commission cannot assess contracts, but is charged by HRSA to complete an Assessment of the Administrative Mechanism (AAM) which evaluates how effectively and quickly allocated resources result in implemented services. Operations was currently addressing the next AAM.

      ➲ Mr. Land will remind DHSP to provide City of Long Beach utilization, surveillance and YR 25 projections data and any federal requirements on patient choice per service category for the 2/17/2015 PP&A meeting.

      ➲ Mr. Land will email Dr. Kushner, Health Officer, City of Long Beach on deferral of the above discussion to 2/17/2015.

      ➲ Mr. Land will email Mr. Engeran-Cordova's AOM contracting suggestion to the Operations Committee for consideration in development of the next Assessment of the Administrative Mechanism.

      MOTION #5: Approve and forward recommendations to Executive Committee, as discussed **(*Postponed*)**.

10. **NEXT STEPS**:
    A. **Task/Assignment Recap**: There was no additional discussion.

    B. **Agenda Development for Next Meeting**: There was no additional discussion.

11. **ANNOUNCEMENTS**: There were no announcements.

12. **ADJOURNMENT**: The meeting adjourned at 3:20 pm.